Piedmont Medical Solutions, Inc.
3540 Clemmons Road, Suite 124
Clemmons, NC 27012
Office: 336-602-1668 Fax: 866-211-2286

Order Date _____/_____/_____ ❑ Initial ❑ Renewal

Patient Name:______________________________ DOB: ________________Sex: ________
Patient Phone: ____________________________ Length of Need**:_99 months / lifetime_**

Diagnosis: ❑ R33.9 - Urinary Retention ❑ R32 - Urinary Incontinence ❑ Other: ________________

The patient's condition is a permanent condition and will persist for 3 months or greater? ❑ Yes ❑No

Equipment: Urinary Supplies	Quantity:	Size:
☐ A4351 Intermittent Urinary Catheters, Straight Tip	______/month	____French
☐ A4352 Intermittent Urinary Catheters, Coude Tip	______/month	____French
☐ A4353 Intermittent Urinary Catheters, Closed System Kit w/collection bag	______/month	____French
☐ A4338 Foley Catheter	______/month	____French
☐ A4338 Supra-Pubic Catheter (up to size 24 French)	______/month	____French
☐ A4310 Insertion Tray	______/month	
☐ A4402 Lubricant for Urinary Catheter insertion – 4 oz. tube	______/month	
☐ A4332 Lubricant, Individual Sterile Packet, Each	______/month	
☐ A4349 Male External Catheters	______/month	
☐ A4357 Bedside Urinary Drainage Bag	______/month	
☐ A4358 Leg or Abdomen Urinary Drainage Bag, vinyl	______/month	
☐ Melio Self-Emptying Leg Bag System: ☐ A4357 Night Bags(2) ☐ A4358 Daytime Bags(2) ☐ A4334 Thigh Strap ☐ A4331 Extension Drain Tube ☐ A5114 Leg Straps (pair)	______/month	_____French
☐ Other: ______________________________________	______/month	_____French

Frequency of Change: _______ /Day

☐ L7900 ED Vacuum Pump

Physician Name:______________________________
Phone #: (___) ______________________________
Physician NPI #:______________________________

We honor those women who have been diagnosed with Ovarian Cancer and the valiant battle they fight every day – past and present - with an ongoing 5% donation of monthly Catheter revenues to the Forsyth Medical Center Foundation GYN Cancer Fund.

______________________________ ______________________________
Physician Signature Date

Fax this form to 866-211-2286 with the following: 1. Clinical notes with diagnosis 2. Patient Demographics 3. Copy of patient insurance card

Visit us at: www.piedmontmedicalsolutions.com